

# Vermont Health Access Pharmacy Benefit Management Program Provider Manual 2008



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## **Introduction**

Pharmacy claims for Vermont's publicly funded programs are processed by our pharmacy benefit management company – **MedMetrics Health Partners (MHP)**.

This Provider Manual consists of a list of contacts, program specific information, a list of information resources and web links, and payer specifications. All of this material will be updated periodically as needed. For the most current version go to:

<http://ovha.vermont.gov/for-providers>

For Vermont's purposes, here and hereafter all references to Vermont Medicaid will mean all publicly funded health assistance programs in current use (Medicaid, Dr. Dynasaur, Vermont Health Access Plan (VHAP), PC Plus, VHAP-Pharmacy, VScript, VScript Expanded, VPharm, Healthy Vermonters, General Assistance and HIV/AIDS Medication Assistance).

## **Help Desk Telephone Numbers**

<b>Responsibility</b>	<b>Help Desk</b>	<b>Phone Numbers</b>	<b>Availability</b>
<b>Recipient:</b>			
Beneficiary	Vermont Member Services Unit	800-250-8427	M-F 8:00AM – 4:30PM (excluding holidays)
<b>Provider:</b>			
EDS*	Provider Enrollment and Payment	800-925-1706 (in state) 802-878-7871 (out of state)	M-F 8:00AM – 5:00PM
MedMetrics Health Partners	Pharmacy Help Desk / Claims-related Technical Call Center	800-918-7545	24/7/365
MedMetrics Health Partners	Clinical Call Center /Prior Authorizations	800-918-7549 866-767-2649 (fax)	24/7/365
Diane Neal, RPh MedMetrics Health Partners	Clinical Staff (Williston, Vermont)	802-879-5605 802-879-5919 (fax)	M-F 8:00AM – 4:30PM (excluding holidays)
Mike Bassett AMAP Coordinator Vermont Department of Health	Prior Authorization (Designated drugs on the HIV/AIDS Medication Assistance Program list only)	802-527-5576 (phone)	M-F 8:00AM – 4:30PM (excluding holidays)
Nancy Miner, CPhT MedMetrics Health Partners	Program Representative	802-879-5638	M-F 8:00AM – 4:30PM (excluding holidays)

\*EDS will continue to handle provider enrollments and process and distribute pharmacy provider reimbursements and remittance advices (RAs).

## **Important Addresses**

<b><u>Provider Paper Claims Billing Address:</u></b> MedMetrics Health Partners Vermont Medicaid Paper Claims Processing Unit 312 Hurricane Lane, Suite 201 Williston, VT 05495 (802) 879-5638	<b><u>Notes:</u></b>  Format: Universal Claim Form (UCF)
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<b><u>MedMetrics (MHP)/Office of Vermont Health Access (OVHA) Operations</u></b> 312 Hurricane Lane, Suite 201 Williston, VT 05495
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## **Important Vermont Pharmacy Program Web Links**

Office of Vermont Health Access (OVHA): <http://ovha.vermont.gov/>

OVHA/MHP Provider Services and Claims Processing: <http://ovha.vermont.gov/for-providers>

EDS Provider Enrollment and Payment: [www.vtmedicaid.com/](http://www.vtmedicaid.com/)

Coverage Chart for Pharmacy Only Programs:

[http://ovha.vermont.gov/for-providers/2006-03-03-pharmacy\\_programs\\_grid\\_revised.pdf](http://ovha.vermont.gov/for-providers/2006-03-03-pharmacy_programs_grid_revised.pdf)

Medicare Non-Covered Drug Grid:

<http://ovha.vermont.gov/for-providers/medicare-part-d-resources>

Beneficiary Aid Category List:

<http://www.vtmedicaid.com/Information/whatsnew.html>

Vermont Health Access Pharmacy Benefit Management Program:

<http://ovha.vermont.gov/for-providers/pharmacy-benefits-management-program-1>

Drug Utilization Review Board:

<http://ovha.vermont.gov/administration>

Preferred Drug List and Drugs that Require PA: <http://ovha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria>

Clinical Criteria and Advisories: <http://ovha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria>

Prior Authorization Forms:

<http://ovha.vermont.gov/for-providers/pharmacy-prior-authorization-request-forms>

Pharmacy Bulletins and Alerts: <http://ovha.vermont.gov/for-providers/pharmacy-programs-bulletins-alerts>

Active Enrolled Provider/Prescriber Listing: [www.vtmedicaid.com/Downloads/manuals.html](http://www.vtmedicaid.com/Downloads/manuals.html)

VScript Expanded Participating Labelers – Numeric: <http://ovha.vermont.gov/for-providers/v-scriptparticipants06-29-07numeric.pdf>

VScript Expanded Participating Labelers – Alpha: <http://ovha.vermont.gov/for-providers/v-script-labelers>  
<http://ovha.vermont.gov/for-providers/v-scriptparticipants06-29-07alphabetical.pdf>

Pharmacy Provider Manual: [http://ovha.vermont.gov/for-providers/microsoft\\_word\\_-\\_provider\\_manual\\_081507.pdf](http://ovha.vermont.gov/for-providers/microsoft_word_-_provider_manual_081507.pdf)

Pharmacy Payer Specifications: <http://ovha.vermont.gov/for-providers/medmetrics-health-partners-mhp-billing-information>

## **Drug Coverage**

General coverage rules are as follows:

Medicaid as a unique program covers most prescription drugs with the exceptions found here. General coverage conditions under Medicaid pharmacy and the pharmacy only programs can be found at:

[http://ovha.vermont.gov/for-providers/2006-03-03-pharmacy\\_programs\\_grid\\_revised.pdf](http://ovha.vermont.gov/for-providers/2006-03-03-pharmacy_programs_grid_revised.pdf)

Each beneficiary is assigned an Aid Category Code. This code identifies the program that provides coverage. A crosswalk of programs to codes can be found in the Aid Category List: <http://www.vtmedicaid.com/Information/whatsnew.html>

The following drugs/drug classes are not covered through the pharmacy benefit:

1. DESI drugs
2. Experimental drugs (DEA = 1)
3. Fertility agents
4. OTCs not covered: shampoos and most non-drug items

Drug coverage is contingent upon CMS rebate agreements with the manufacturers. VScript Expanded and VPharm 3 have additional rebate requirements. Exception: Diabetic supplies will pay regardless of rebate. Glucometers over \$60 require PA.

Some supplies may be submitted on-line (e.g., diabetic supplies and family planning supplies such as condoms). The supply must have a corresponding NDC.

Claims for all other supplies, including those used for incontinence, should be submitted on a CMS 1500 form to EDS.

Nutritional supplements may be submitted online.

### ***Exceptions to VScript Maintenance List***

The VScript drug program provides coverage for prescription medications (and limited OTCs) which are considered maintenance therapies. If a claim denies for a drug because it is not on the VScript Maintenance List (Appendix A), and you believe that the drug product (or drug class) should be covered for all VScript patients because it is more often than not utilized for chronic maintenance purposes, you may call the Clinical Call Center at 800-918-7549 with your recommendations. Please note, however, that the narcotic class of agents, both long-acting and short-acting agents, is not considered to be a maintenance drug category.

If a claim denies for a VScript member because the drug is not on the VScript maintenance list and its use for this individual patient will be for maintenance purposes, then please advise the patient to contact his or her physician to request a Prior Authorization.

### ***Custom Program Messaging***

In an effort to help pharmacies to better know / understand a beneficiary's program eligibility/coverage, custom messages have been added to the claim processing responses. The following message will appear when a claim is processed for a member in the respective program. This message will appear regardless of how the claim processes (i.e., pays or rejects) and will appear after specific messaging that refers to the cause of a reject.

MEDICAID / DR. DINOSAUR	"Medicaid coverage"
VHAP	"VHAP Coverage"
VSCRIPT	"Maintenance List Applies"
VSCRIPT EXPANDED	"Limited Maintenance List Applies"
VPHARM 1 (VPHARM/VHAP)	"Part D VHAP Wrap"
VPHARM 2 (VPHARM/VSCRIPT)	"Part D Maintenance-Only Wrap"
VPHARM 3 (VPHARM/VSCRIPT EXP)	"Part D Ltd. Maintenance Wrap"

### **Prior Authorization**

Prior authorization may be required for all programs except General Assistance and Healthy Vermonters.

All drugs requiring prior authorization can be identified on the Preferred Drug List. The List and Criteria for prior authorization can be found at:

<http://ovha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria>

Prior authorizations may be faxed to the number below.

<b>Responsibility</b>	<b>Help Desk</b>	<b>Phone Numbers</b>	<b>Availability</b>
MedMetrics Health Partners	Clinical Call Center /Prior Authorizations	800-918-7549 866-767-2649 (fax)	24/7/365

### **Emergency 72-Hour Fill**

An emergency fill provision can be instituted by MedMetrics when a required prior authorization has not been secured, and the need to fill the prescription is determined to be an emergency. If the prescriber cannot be reached to obtain the required prior authorization, the pharmacist may contact MedMetrics for authorization to dispense an emergency supply to last up to 72 hours. If the emergency persists, refills can be available. This emergency 72-hour fill provision is Federal law (Title 19, Section 1927(D)(5)(b)) and is applicable only to medications that are covered by Vermont's pharmacy programs.

## **General Assistance**

Beneficiaries may be enrolled in General Assistance in one of two ways:

- General Assistance only; i.e., there is no other “primary” Medicaid coverage; *or*
- General Assistance as secondary coverage with another Medicaid program as primary.

Coverage is limited to classes of drugs identified as likely to create an emergency if not covered.

In those cases where a beneficiary makes a payment, the provider must submit the amount in the PATIENT PAID AMOUNT field.

## **Generic Substitution Policy**

Vermont law requires that when available, the therapeutically equivalent generic product should be dispensed.

MAC pricing may be overridden by the provider in the following conditions:

1. The prescriber has mandated brand, noting “Brand Medically Necessary” on the prescription and indicated in writing or verbally why a brand is required. In this case, the pharmacy provider should submit a Dispense as Written Code (DAW) of “1”.
2. The generic is not available in the marketplace. In this case, the pharmacy provider should submit a Dispense as Written Code (DAW) of “8”. Note that this does not mean that it is not available in the store. DAW8 may only be used when the generic is not generally available in the community. The provider should keep appropriate documentation to support this condition.

Additionally:

1. Brand drugs that are considered to have a narrow therapeutic index will bypass MAC pricing.
2. In select situations, the state reserves the right to make the determination that a branded product is the preferred product when a newly-FDA-approved generic equivalent agent proves more costly to the State than its branded counterpart. If, upon launch, it is determined that the generic will be priced at a level greater than the net cost of the brand, OVHA may require a prior authorization for the generic until that time when generic pricing falls below that of the net cost of the branded product.

## **Long-Term Care (LTC) Nursing Home Claims**

LTC nursing home claims are identified by a value of “3” in the PATIENT LOCATION field on the claim.

Some drugs and supplies are not covered for LTC nursing home patients through POS as they are covered in the patient’s per-diem. With the exception of insulin, needles and syringes, OTC drugs and products are not covered.

There is no copay to the recipient on LTC claims.

Providers submitting LTC claims are limited to one dispensing fee per patient per covered drug per month (“per month” will be considered 75% of a 34-day supply; this allows the provider to a limit of one dispense fee per every 25 days). “Per covered drug” will be considered “per GPI” (*Definition:* A GPI, or Generic Product Indicator, includes all drugs sharing the same chemical composition, in the same strength, in the same form and that are administered via the same route.) Providers may override the single dispense fee limit for mitigating circumstances by entering a value of “5” (exemption from prescription limits) in the PRIOR AUTHORIZATION TYPE CODE field for cases where:

- The physician has prescribed a second round of medication within the 25-day period.
- The physician has increased the dose.
- The medication did not last for the intended days supply.
- The drug has been compromised by accident (e.g., contaminated or destroyed).
- The medication is being dispensed due to the patient’s LOA (leave of absence) from the institution.
- The dispensing of controlled substances is limited due to concern regarding patient’s ability to take appropriately.

Except for controlled substances, unused or modified unit dose medication that is in reusable condition and which may be returned to a pharmacy pursuant to state laws, rules or regulations shall be returned from LTC facilities to the provider pharmacy. The provider should resubmit the claim with the appropriate quantity dispensed.

## **Special Claims**

### ***Multi-Ingredient Compound Claims***

- Ingredients will be priced at the lesser of AWP – 11.9%, the MAC, or the FUL.
- The ingredients' costs will be totaled and priced at the lesser of the calculated cost or the claim's U&C cost.
- Containers other than syringes are included in the dispensing fee.
- Syringes must be billed as part of the compounded claim. They are not subject to a separate dispensing fee or compounding fee.
- A compound fee (professional services fee) of \$15.00 will be automatically added to all prescriptions submitted with a compound indicator of "2" (in addition to the regular \$4.75 in-state or \$3.65 out-of-state dispensing fee).

- All compounds must contain **more than 1 ingredient**. Compounds submitted with only 1 ingredient will reject with a reject code of 76 with local messaging of “Minimum ingredients of 2.”
- **Compound indicator must be “2”** (indicating a multi-ingredient compound).
- **NDC field in claim segment (i.e. Product/Service ID)** (not individual ingredients) must contain **11 zeros**. If an actual individual NDC is submitted in the Product/Service ID, the claim will reject with a reject code of 70 with local messaging of “Submit 11 zeros in the Product/Service ID and complete compound detail – more than 1 ingredient required.”

Any questions about the submission of claims for compounded medications should be directed to the MedMetrics Clinical Call Center at 1-800-918-7549.

### ***Paper Claims***

- The Universal Claim Form (UCF) will be required for all paper claims.
- The UCF should be submitted to MHP for processing.
- UCFs may be obtained from Moore Document Solutions:  
Moore Document Solutions  
410 N. 44th Street, Suite 300  
Phoenix, AZ 85008  
800-635-9500

## **Prospective Drug Utilization Review (ProDUR)**

ProDUR is an integral part of the Vermont Medicaid claims adjudication process. ProDUR includes: reviewing claims for therapeutic appropriateness before the medication is dispensed, reviewing the available medical history, focusing on those patients at the highest severity of risk for harmful outcome, and intervening and/or counseling when appropriate.

Prospective Drug Utilization Review (ProDUR) encompasses the detection, evaluation, and counseling components of pre-dispensing drug therapy screening. The ProDUR system addresses situations in which potential drug problems may exist. ProDUR performed prior to dispensing ensures that patients receive appropriate medications. This is accomplished by providing information to the dispensing pharmacist that may not have been previously available.

Because ProDUR examines claims from all participating pharmacies, drugs which interact or are affected by previously dispensed medications can be detected. While the pharmacist uses his/her education and professional judgment in all aspects of dispensing, ProDUR is intended an informational tool to aid the pharmacist.

### ***Therapeutic Problems***

The following ProDUR Reason of Service types will deny for the Vermont Medicaid program:

- Drug-to-Drug Interaction
- Therapeutic Duplication
- Ingredient Duplication

ProDUR Edits that deny may be overridden at POS using the interactive NCPDP DUR override codes (see below). ProDUR denial edits will apply to all media types.

### **DUR OVERRIDE PROCESSING (NCPDP Reject Code 88)**

**When a claim is rejected for a DUR edit, pharmacies may override the denial by submitting the appropriate DUR Reason for Service, Professional Service, and Result of Service codes.**

Below you will find a chart that details the Professional Service and Result of Service codes that will override a claim that has been denied for Drug-to-Drug Interaction, Ingredient Duplication and/or Therapeutic Duplication. Note that the designated Professional Service Code must accompany the appropriate Result of Service code as indicated in the chart to allow the override.

## **DUR REJECT OVERRIDE PROCESSING (NCPDP Reject Code 88)**

The valid DUR Reason for Service Codes for Vermont Medicaid are:

DD - Drug-Drug Interaction  
ID - Ingredient Duplication  
TD - Therapeutic Duplication

The only acceptable Professional Service Codes are:

MR – Medication Review  
M0 – Prescriber Consulted  
R0 – Pharmacist Consulted Other

Please note that the designated Professional Service Code must accompany the appropriate Result of Service code as indicated below to allow the override:

<b>DUR REASON FOR SERVICE (Conflict)</b>	<b>PROFESSIONAL SERVICE CODE (Intervention)</b>		<b>RESULT OF SERVICE CODE (Outcome)</b>	
	<b>CODE</b>	<b>DESCRIPTION</b>	<b>CODE</b>	<b>DESCRIPTION</b>
<b>DD, ID, TD</b>				
	<b>MR</b>	Medication review	<b>1B</b>	Filled prescription as is
	<b>M0</b>	Prescriber consulted		
	<b>R0</b>	Consulted other		
	<b>M0</b>	Prescriber consulted	<b>1C</b>	Filled with different dose
	<b>R0</b>	Consulted other		
	<b>MR</b>	Medication review	<b>1D</b>	Filled with different directions
	<b>M0</b>	Prescriber consulted		
	<b>R0</b>	Consulted other		
	<b>MR</b>	Medication review	<b>3E</b>	Therapy changed
	<b>M0</b>	Prescriber consulted		
	<b>R0</b>	Consulted other		

### ***Days Supply***

Accurate days supply reports are required on all claims. Submitting incorrect days supply information in the days supply field can cause false ProDUR messages or claim denial for that particular claim and/or for drug claims that are submitted in the future.

### ***ProDUR Support***

MHP's Technical Call Center is available 24 hours per day, seven days per week. The telephone number is 800-918-7545. Alert message information is available from the Call Center after the message appears. If you need assistance with any alert or denial messages, it is important to contact the Call Center about ProDUR messages at the time of dispensing. The Call Center can provide claims information on all error messages which are sent by the ProDUR system. This information includes: NDCs and drug names of the affected drugs, dates of service, whether the calling pharmacy is the dispensing pharmacy of the conflicting drug, and days supply.

The Technical Call Center is not intended to be used as a clinical consulting service and cannot replace or supplement the professional judgment of the dispensing pharmacist. MHP has used reasonable care to accurately compile ProDUR information. Because each clinical situation is unique, this information is intended for pharmacists to use at their own discretion in the drug therapy management of their patients.

A second level of assistance is available if a provider's question requires a clinical response. To address these situations, MHP staff pharmacists are available for consultation.

### ***ProDUR Alert/Error Messages***

All messages appear in the claims adjudication transmission. See Payer Specifications for more information.

## **Timely Filing Limits**

Most providers submitting point of sale submit their claims at the time of dispensing. However, there may be mitigating reasons that require a claim to be submitted after the fact.

- For all original claims, reversals and re-bills, the timely filing limit is **183 days** from the date of service (DOS).
- Claims that exceed the prescribed timely filing limit will deny.
- When appropriate, contact MHP for consideration of an override to timely filing limits.
- Requests for overrides will be considered for:
  1. Retroactive beneficiary eligibility
  2. COB delay
  3. Denial date (depending on original adjudication date)
  4. At the State's request
- Overrides for timely filing limits exceeded greater than two years from the date of service will not be authorized.

Requests for overrides should be mailed to:

MedMetrics Health Partners  
Vermont Medicaid Paper Claims Processing Unit  
312 Hurricane Lane, Suite 201  
Williston, VT 05495

Call the MHP Program Representative with any questions at (802) 879-5638.

## **Dispensing Limits**

### **Days Supply:**

- Non-maintenance drugs (*Definition:* medications used on an “as needed” basis) are subject to a per claim days’ supply maximum limit of **34**. There is no days supply minimum.
- Maintenance drugs (*Definition:* used continuously for 30 days or more) are subject to a per-claim minimum days’ supply of 30 and a maximum days supply of **102**. If there are extenuating circumstances in an individual case which, in the judgment of the prescribing physician, dictate a shorter prescribing period, the supply may be for less than 30 days. Certain drugs have maximum quantity limits other than described here (see “Quantity Limits” below).
- A 102 day supply is allowed for all covered Vitamins.
- V-Script beneficiaries may receive up to a **90**-day supply of any drug on their coverage list. The V-Script Covered and Non-Covered Drug Lists are included as appendices at the back of this document.
- Claims will deny if the days supply limit is exceeded.
- The MHP PA Unit will respond to dispensing limit override requests.
- Exceptions to standard days supply limits:
  1. Fluoride quantity limit is 102.
  2. Oral Contraceptives may be dispensed in a quantity not to exceed a 92-day supply.
  3. Prenatal Vitamins minimum quantity is 90 and maximum quantity is 102.

Requests for overrides should go to the MHP Clinical Call Center.

### **Quantity Limits:**

All Quantity Limits are identified in the Preferred Drug List. The Preferred Drug List can be found at <http://ovha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria>

### **Refills:**

- All refills must be dispensed in accordance with State and Federal requirements.
- Refill prescriptions must be dispensed pursuant to the orders of the physician, but not more than one year from the date of the original prescription.
- Refills must not exceed 5 refills (plus one original).
- For DEA code = “3”, “4”, “5”: allow up to 5 refills (plus one original) or 6 months, whichever comes first.
- For DEA code = “2” no refills are allowed; a new prescription is required for each fill.

### **Early Refill Overrides (NCPDP Reject Code 79):**

Pharmacies may override claim rejections for early refill. To override this edit:

1. Enter the appropriate Submission Clarification Code (see below for acceptable options).
2. In the Prior Authorization (PA) type field: enter “02.”
3. In the PA number field: enter “4.” (Depending on your software, you may need to add up to ten leading or trailing zeros in the PA type field.)

#### Submission Clarification Code / Description

00/ not specified	<b>Not acceptable for early refill override</b>
01/ no override	<b>Not acceptable for early refill override</b>
02/ other override	<b>Not acceptable for early refill override</b>
03/ vacation supply	Acceptable; use for vacations and LTC leave of absence
04/ lost prescription	Acceptable
05/ therapy	Acceptable; use when prescriber changes dose
06/ starter dose	Acceptable
07/ medically necessary	Acceptable

### **Provider Dispensing/Compounding Fees**

- The dispensing fee for in-state pharmacies is \$4.75. For maintenance drugs, one dispensing fee per 30 days is permitted. However, if there are extenuating circumstances in an individual case which, in the judgment of the prescribing physician, dictate a shorter prescribing period, the supply may be for less than 30 days, in which case a dispensing fee would be paid for each fill as prescribed.
- The dispensing fee for out-of-state pharmacies is \$3.65.
- An additional compounding fee is paid in addition to the dispensing fee for compound drug claims. (See page 12.)
- Exceptions:
  - There is a limited dispensing fee for LTC claims; i.e. one per every 25 days per patient per covered drug (per GPI).
  - No dispensing fee for glucometers.

## **Recipient Payment Information**

Vermont programs have no deductibles and no benefit maximums.

When traditional Medicaid coverage is primary, copayments are:

- \$1 if allowed amount is equal to or less than \$29.99.
- \$2 if allowed amount is greater than or equal to \$30.00 but less than or equal to \$49.99.
- \$3 if allowed amount is equal to or greater than \$50.00.

Exceptions (no copayments apply):

- Patient 20 years and younger (based on Eligibility File)
- Drug is family planning drug
- Patient is pregnant or in the 60-day post-pregnancy period (requires a prior authorization obtained by calling MedMetrics Clinical Call Center at 800-918-7549)
- Claim is licensed nursing home LTC claim (**require PATIENT LOCATION = “03” on the claim to indicate licensed nursing home LTC**)
- Medical supplies

When Healthy Vermonter coverage applies, the beneficiary pays the full allowed amount.

Full-benefit dual eligible beneficiaries (those who have both Medicaid and a Medicare Part D Plan) are responsible for copayments up to \$5.35 charged by the Part D Plan for 2007. Effective January 1, 2008, the maximum copayment amount will increase to \$5.60. For those beneficiaries who are enrolled in a VPharm (Part D wrap) program, Part D plan deductibles and coinsurance should be billed to VPharm. For further clarification on how VPharm plans interact with Medicare Part D, see:

[http://ovha.vermont.gov/for-providers/2006-03-03-pharmacy\\_programs\\_grid\\_revised.pdf](http://ovha.vermont.gov/for-providers/2006-03-03-pharmacy_programs_grid_revised.pdf)

## **Coordination of Benefits**

The following provides information on submitting COB claims.

Claim segment and field requirements are detailed in the Consolidated Payer Specification Sheet.

Required information on a secondary claim may include:

- Submitted Patient Pay
- Other Coverage Code
- Other Payer Amount
- Other Payer Date
- Other Payer ID Qualifier
- Other Payer ID

The state-assigned Other Payer IDs can be found on the Active Payer and PDP Sponsor Lists found at

<http://ovha.vermont.gov/for-providers/Active%20Carrier%20Codes%201%2007.pdf>. These lists are:

- insurance carriers / sponsors for COB claims filed under PCN VTM
- Medicare Part D Plan Sponsors for COB claims filed under PCN VTD

Providers may submit up to three segments of information when there are multiple other payers.

***Required fields:***

**Submitted Patient Pay (NCPDP Field # 433-DX):** Required on all secondary claims. The submitted Patient Pay field details the amount of the copay required by the member's primary payer.

**Other Payer Coverage Code (NCPDP Field #308-C8):** Required on all secondary claims. The Other Payer Coverage Code indicates the type of coverage the other insurer is providing for the claim. (See chart below for possible scenarios and circumstances.)

<b>Other Coverage Code / Description</b>	<b>Processing Policy Vermont Coverage Secondary to Alternate Insurance</b>	<b>Processing Policy Vermont Coverage Secondary to Medicare Part D Plan</b>
0 = Not Specified	Claim will reject	Claim will reject.
1 = No other coverage identified	Claim will reject	Claim will reject.
2 = Other coverage exists, payment collected from primary.	Requires Submitted Patient Pay field and COB segment, detailing information on paid claim, including Other Payer ID and Other Payer Paid Amount. Claim will process based on Medicaid allowed amount.	Requires Submitted Patient Pay field and COB segment, detailing information on paid claim, including Other Payer ID and Other Payer Paid Amount – claim will pay based on member cost share from PDP. OCC2 does not apply to full-benefit duals.
3 = Other coverage exists, claim rejected by primary	Should only be submitted if the primary insurance carrier returned a reject code of <i>70-NDC Not Covered</i> denial. If the primary payer requires a Prior Authorization, then the primary carrier's Prior Authorization procedures must be followed. State would prefer Other Payer Reject Code, but field is not currently required. State will process claims rejected by primary payer.	Claims submitted with an OCC = 3 will be subject to an edit to determine if drug class is Excluded from Part D coverage by CMS; if so, state will pay claim if all other state criteria is met. If product is not an Excluded Drug from CMS for Part D coverage, state will reject claim. State would prefer Other Payer Reject Code, but field is not currently required.

<b>Other Coverage Code / Description</b>	<b>Processing Policy Vermont Coverage Secondary to Alternate Insurance</b>	<b>Processing Policy Vermont Coverage Secondary to Medicare Part D Plan</b>
4 = Other coverage exists, payment not collected from primary	To be used when member has deductible and primary payer is not making payment on claim; requires Submitted Patient Pay field and complete COB segment. Claim will pay based on Medicaid allowed amount.	To be used when member has deductible or “donut hole” and primary payer is not making payment on claim; requires Submitted Patient Pay field and complete COB segment. Claim will pay based on member cost share from PDP. Also used for Part B deductible. OCC4 does not apply to Part D claims for full-benefit duals.
5 = Managed Care Plan denial	Claim will reject	Claim will reject.
6 = Other coverage Denied, not a participating provider	Claim will reject	Claim will reject.
7 = Other coverage exists, not in effect on Date of Service (DOS)	To be used if member’s other coverage no longer exists; state will process claim	Claim will reject.
8 = Claim is billing for copay  <i>Note: for Part D wrap - used only when Other Payer Amount = &lt;\$0</i>	Not applicable	<i>(Only used when Other Payer Paid Amount is \$&lt;0)</i> Requires Submitted Patient Pay field and COB segment, detailing information on paid claim, including Other Payer ID and <i>negative</i> Other Payer Paid Amount. Claim will pay based on member cost sharing.

**Other Payer ID Qualifier (NCPDP Field #339-6C):** Required on claims where the Other Coverage Code (OCC) = “2” or “8”. The Other Payer ID Qualifier will always be “99 – Other”, since the list is a state-issued list of payers.

**Other Payer ID (NCPDP Field #339-7C):** Required on claims where the Other Coverage Code (OCC) = “2” or “8”. The Other Payer ID is a unique three-digit carrier code that identifies the other insurer; the state issues and maintains that list of codes. For Medicare Part D secondary claims, the state maintains a list of the Part D plan sponsors. For other Medicaid secondary claims, the state maintains a complete list of potential insurers.

**Other Payer Amount Paid (NCPDP Field #431-DV):** Required on claims where the Other Coverage Code (OCC) = “2” or “8”. The Other Payer Amount Paid is the dollar amount of the payment received from the primary payer(s).

**Other Payer Date (NCPDP Field #443-E8):** Required on all secondary claims. The Other Payer Date is the payment or denial date of the claim submitted to the other payer.

**Other Payer Reject Code (NCPDP Field #472-6E):** The Other Payer Reject Code is not currently required, but is supported by the state when the Other Coverage Code (OCC) = 3.

## **Medicare**

### ***Part B:***

Vermont program coverage is always secondary to Medicare Part B Coverage. As of July 1, 2006, Medicare Part B prescription drug claims with NDCs are processed by MedMetrics Health Partners. EDS is no longer processing Medicare Part B crossover and paper claims.

Medicare Part B Covered Drugs:

- Oral Cancer Drugs
- Immunosuppressants
- Nebulizer Solutions
- Diabetic Supplies

**To override the “Medicare as primary” requirement, pharmacies must first bill Medicare B, receive a denial, and then contact the MedMetrics Clinical Call Center at 1-800-918-7549. Pharmacies are no longer able to override at point of sale by entering 88888 in the other payer ID field.**

### ***Part D:***

Effective January 1, 2006, Vermont beneficiaries who are Medicare eligibles will be enrolled in a Part D plan for primary coverage, with only a secondary benefit provided by Vermont programs.

Use an E1 request to determine if the member is enrolled in a Part D plan. If the member is enrolled in a Part D Plan, the E1 response will identify where to send the primary payment request as well as the processing information to submit to Medicaid for any secondary claim.

Vermont Medicaid members who have Part D coverage are eligible for a “wrap” benefit by the state. Depending on a member’s eligibility and the product that you are dispensing, this benefit may be a financial or a formulary wrap to the Part D vendor’s (PDP’s) benefit. Generally, coverage parallels coverage in Vermont programs (Medicaid, VHAP, VHAP Pharmacy, VScript, and VScript Expanded). See the Vermont Pharmacy Programs Coverage Chart for the most current information:

[http://ovha.vermont.gov/for-providers/2006-03-03-pharmacy\\_programs\\_grid\\_revised.pdf](http://ovha.vermont.gov/for-providers/2006-03-03-pharmacy_programs_grid_revised.pdf)

See the MedMetrics Health Partner Consolidated Payer Sheet for claims submittal information.

***Part C:***

As of January 1, 2007, Medicare members in Vermont will have the option of joining a Medicare Part C plan. Medicare Part C consists of several Medicare Advantage Plan choices that are Medicare-approved and administered by private insurance companies.

- The Medicare Advantage Plans will replace Part A and Part B for members who choose to join. Some Medicare Advantage Plans also include drug coverage (Part D).
- For those plans that do not include Part D drug coverage, the member will need to have a separate Part D Plan in order to receive a pharmacy benefit.

**When a beneficiary is covered by both Medicare B and D, drug claims must be processed by the appropriate insurer prior to submitting any balances to MedMetrics. OVHA will closely monitor this process.**

## **Payer Specifications**

Current specifications can be found on the website for the Office of Vermont Health Access on the Provider Services and Claims Processing Page at:

<http://ovha.vermont.gov/for-providers/medmetrics-health-partners-mhp-billing-information>

The Payer Specifications include details on claims submissions, host information, claims processing messages, submission clarifications, DUR information, DUR service codes, and COB messages.

## **BIN/PCN Numbers**

<b>Claims for Vermont Members</b>	
ANSI BIN #	<b>610593</b>
Processor Control #	<b>VTM</b>
Group #	VTMEDICAID
Carrier	MPSOVHA
Provider ID #	NCPDP Number
Cardholder ID #	Vermont Medicaid ID Number
Prescriber ID #	Vermont Prescriber ID (prescriber specific)
Product Code	National Drug Code (NDC)

<b>Claims for Vermont Medicaid Members w/Part D Coverage</b>	
ANSI BIN #	<b>610593</b>
Processor Control #	<b>VTD</b>
Group #	VTMEDICAID
Carrier	MPSOVHAD
Provider ID #	NCPDP Number
Cardholder ID #	Vermont Medicaid ID Number
Prescriber ID #	Vermont Prescriber ID (prescriber specific)
Product Code	National Drug Code (NDC)

## **Provider Reimbursement**

### ***Provider Payment Algorithm***

- Vermont Medicaid is the payer of last resort after other insurers.
- Vermont Medicaid programs pay the lesser of:
  1. AWP – 11.9% + dispensing fee
  2. HCFA FUL + dispensing fee
  3. MAC + dispensing fee
  4. U/C (includes dispensing fee)

### ***Secondary Claims (claims when other insurance is primary)\****

1. Part D: For secondary claims when the Part D plan is the primary payer, Vermont Medicaid pays the amount designated in the claims “Patient Pay” field.
2. Non-Part D: When other insurance is the primary payer, Vermont Medicaid pays the allowed amount as determined in the above payment algorithm reduced by the primary insurance payment.

\* See Coordination of Benefits, pages 22 to 25.

### ***Provider Reimbursement Schedule***

The payment and Remittance Advice schedule is weekly.

## **Appendix A**

### **VScript Covered Maintenance Drug Categories**

- ADD/ADHD Treatments
- Adrenergic Agents
- Alzheimer's Disease Medications
- Angina(Chest Pain) Treatments
- Anticoagulants/Blood Thinners
- Anticonvulsants/Epilepsy Treatments
- Antidepressants
- Anti-Inflammatory Agents
- Antimalarials
- Antipsychotics/Schizophrenia Treatments
- Antiretrovirals
- Anti-ulcer/Reflux Treatments
- Anxiety Treatments
- Arthritis Treatments
- Asthma/COPD Treatments
- Bipolar Treatments
- Blood Cell Stimulators
- Cancer meds
- Cholesterol-Lowering Agents
- Contraceptives (oral/systemic)
- Diabetic Therapy
- Digestive Enzymes
- Diuretics
- Electrolytes & Miscellaneous Nutrients
- Estrogens
- Folic Acid Preparations
- Gall Stone/Kidney Stone Treatments
- Heart Arrhythmia Treatments
- Heart Failure Treatments
- Hypertension Treatments
- Irritable Bowel Treatments
- Local (topical) Anesthetics
- Non-Narcotic analgesics
- Ophthalmic preparations
- Other Cardiovascular Treatments
- Other CNS Treatments
- Overactive Bladder Treatments
- Parkinson's Disease Medications
- Progesterone
- Systemic Steroids (Glucocorticoids/Mineralocorticoids)
- Testosterone Replacement Therapy
- Thyroid Preparations
- Tuberculosis (TB) Treatments
- Urinary Antibacterials

## Appendix B

### VScript Non-Covered Drug Categories

#### **Non-Coverage Based Upon General Use for the Treatment of Acute Conditions**

- Antibiotics (most classes)
- Antidotes (**agents used to treat accidental poisoning or overdose**)
- Antihistamines
- Antiseptics
- Antithyroid preparations
- Antivirals
- Biologicals
- Coal tar (**tar-based skin treatments for conditions like psoriasis or flakey skin**)
- Cough & cold preparations
- Dermatologic treatments
- Diagnostic meds
- Diarrhea Medications
- Digestants
- Emollients protectives (**topical treatments for dry skin**)
- Fertility treatments
- Fungal treatments
- Hemorrhoidal preparations
- Iodine therapy (**iodine-based expectorants used to decrease mucus in various respiratory conditions**)
- Laxatives
- Medical supplies
- Multivitamins
- Muscle relaxants
- Narcotic analgesics
- Nasal preparations
- Nausea treatments
- Obesity preparations
- Otic (ear) preparations
- Parasite treatments
- Sedative/hypnotics
- Vaginal products
- Vitamins (fat-soluble)
- Vitamins (water-soluble)